

Use ACEMAN during U1R28 – a message from Gary VanMiddlesworth

The foundation of Point Beach Excellence is Individual Excellence. Our path to Excellence is based on every individual/employee understanding our Picture of Excellence and how their actions and behaviors integrate into the picture.

Part of demonstrating the picture requires employees to exemplify the six basic individual results. These six basic individual results outline what each one of us, individually, can do to support Point Beach.

Accident Free
Control Dose
Event Free
Meet Schedule
Attend Training
No Rework



I'd like to review some of the events we've had during this outage that demonstrate the importance of individual performance and the impact it has on our overall results.

Letdown gas stripper secured early (CAP055326)

The Unit 1 Letdown Gas Stripper was inadvertently removed from service too early. The Reactor Coolant System hydrogen gas concentration was well above its limit.

Why did it happen? There was a lack of knowledge in the outage schedule, in addition to a lack of communication verifying/validating that the system should be secured.

The gas concentration in the RCS was specifically discussed at the 0600 OCC meeting the day before this event. The gas concentration was high and site management was assured that the letdown gas stripper system would resolve the issue. Later that night the system was secured with gas concentration still high.

Individual results not met: **E**vent free, **M**eeet schedule and **R**ework

Steam generator nozzle dams (CAP055538)

The potential was there to not have a hot leg vent path during the installation of Unit 1 steam generator nozzle dams.

Management communicated at the 0600 OCC turnover meeting the importance of ensuring the hot leg vent path was maintained. In addition, regulatory commitments clearly state in Generic Letter 88-17 and NUREG-1449 the requirement for a hot leg vent path. A hot leg vent path is and was sequenced correctly in the U1R28 outage schedule as follows:

- * Remove hot leg S/G man ways
- * Remove cold leg S/G man ways
- * Install cold leg nozzle dams

- * Remove pressurizer man way (hot leg vent path)
- * Install hot leg nozzle dams

We encountered some difficulties in removing the pressurizer man way, which would have established the hot leg vent path. At this point individuals decided to deviate from the schedule and proceed with the installation of the hot leg nozzle dams – while developing a plan to remove the pressurizer man way.

Why did it happen? Employees were performing in the knowledge base area and proceeded in the face of uncertainty. We should have stopped, got the right people together to adhere to the schedule.

Individual results not met: **C**ontrol dose, **E**vent free, **M**eeet schedule and **R**ework

Bolted fault work; opened wrong breaker during lineup

During preparations for the Bolted Fault modification, the incorrect breaker was opened, which resulted in the loss of the ‘A’ Spent Fuel Pool cooling pump.

An employee was performing the lineup needed for the modification work to begin. The correct breaker was identified, the control room was notified, and then the worker opened the breaker next to the correct one.

Why did it happen? Inattention to detail, failure to self-check, and the lack of obtaining a peer check were a few of the major contributors.

As a result, the work was stopped and the modification was removed from the outage. We later placed the modification back into the outage schedule. As a result of removing the work and reinserting it – additional time was added to the outage.

Individual results not met: **E**vent free, **M**eeet schedule and **R**ework

Polar crane failures

A growling noise was identified on the auxiliary and main hook of the polar crane. This noise was noticed during previous outages; however, with the heightened emphasis on “doing things right” the organization decided to investigate and fix the issue. **THIS IS THE RIGHT BEHAVIOR!**

However, troubleshooting and repair communications (between days and nights) resulted in rework.

Why did it happen? We did not implement the Issue Manager process to establish a single point of ownership. This resulted in plans being changed depending on who was on shift, poor communications also contributed to rework.

Individual results not met: **M**eeet schedule and **R**ework

Reactor head lift; bullet nose inadvertently lifted (CAP055951)

During the Unit 1 reactor head lift, one incore thermocouple guide (bullet nose) was inadvertently lifted along with the head. This prevented cavity flood up.

A white rag used as a temporary FME barrier while preparing the thermocouple penetration for the head lift was inadvertently left. The rag had jammed in the annulus between the T/C bullet nose guide and the head penetration; this caused the guide to be lifted with the head instead of slipping through it and remaining on the upper internals.

Why did it happen? Past practices used the rag as an FME barrier. There wasn't a formal (such as a procedure requirement) barrier in place to ensure it was removed.

Individual results not met: Control dose, Event free, Meet Schedule and Rework

These examples illustrate the importance of individual performances in regards to the Point Beach Picture of Excellence.

It is important to remember: **EVERY TASK, EVERY JOB, EVERY DAY, EVENT FREE.**

By using the Picture of Excellence we will do the job right the first time! Remember to use the individual results associated with ACEMAN.

Ray Van Middlesworth

Point Beach Nuclear Plant U1R28 Refueling Outage

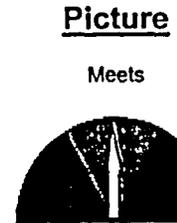
Safety Topics for week of May 2 – 8, 2004
Theme for the week
This week's theme is Hand Protection . During the last week of April, there were a lot of minor hand injuries reported. Although we have come a long way in the last few years, we still have not eliminated hand injuries. It is time we hand protection to the next level.
Daily Safety Snippets
Sunday
"It's difficult to grip when your finger gets snipped" Could you imagine doing your job without your hands? We tend to take it too much for granted that we have two hands at our command, immediately ready to do what we want them to. They not only perform amazing manual tasks, but they also make us money. Just ask anyone who has lost the use of his or her hands.
Monday
"Concerning fingers, do not ignore; Cut one off and you'll grow no more" Limmerk 1999, While lowering a 2000lb. flow diffuser from the high pressure turbine, a worker lost a substantial portion of one finger when the cribbing and jack used to support the diffuser failed and pinned the worker's hand between the diffuser and an I-beam used as part of the cribbing.
Tuesday
"Safety gloves worn is a hand not torn" OE12632 Davis Besse, While performing a search, a security officer ran his hand between the front and back seat of a vehicle. A utility knife with the blade partially open cut the leather outer covering of the search glove, but the Kevlar liner gloves the officer had on protected his hand and prevented a serious injury.
Wednesday
"Where danger lingers, watch your fingers" Workers need to know accidents can happen in the strangest ways. Some accidents are simply bizarre. Others happen when no hazard is apparent. Doors were the source of more than 10,000 hand injuries a year in the US. Vending machines caused more than 100 lost-day hand injuries. And 52 workers injured their hands while walking, according to the statistics.
Thursday
"Practice safety until it fits like a glove" Do you consider gloves as much a part of your normal PPE as your hardhat, safety glasses, and hearing protection? If not, maybe you should be. Always carry a pair of gloves with you when in the plant and use them when operating the valve or picking up scrap metal.
Friday
"A finger tip - don't leave work without them!" On April 4, 2001, a contract employee at Braidwood Station suffered a fractured right hand when an electric hoist disengaged from a crane hook and fell on to the new fuel storage rack. The electric hoist was being used to drag test new spent fuel racks being installed at the station. Workers attached a load cell and the electric hoist to the auxiliary hoist of the fuel building overhead crane, and then connected the electric hoist to a test gage. As the crane operator lowered the auxiliary hook, the test gage hung up on the fuel rack and caused the rigging to move laterally. The electric hoist became disengaged because the safety latch on the auxiliary hook was not used.
Saturday
"It's no hand jive... Proper gloves protect all five" OSHA 1910.138(a): General requirements. Employers shall select and require employees to use appropriate hand protection when employees' hands are exposed to hazards such as those from skin absorption of harmful substances; severe cuts or lacerations; severe abrasions; punctures; chemical burns; thermal burns; and harmful temperature extremes.

Point Beach Nuclear Plant Outage 1R28

DAY 31

Supporting Operational Excellence

Outage Radiation Performance



Doesn't Meet Exceeds

Definition/Goal

Analysis and Actions

This indicator measures cumulative dose radiation exposure and total number of personnel-contamination events (PCE's > 5000 cpm) during refueling outages. The dose indicator is measured in Rem and individual PCE events.

Day 31 - May 4
 Actual = 0.907
 Cumulative = 51.104
 Cumulative Forecast = 59.488

Daily dose and PCE goals reforecasted on 4/23.

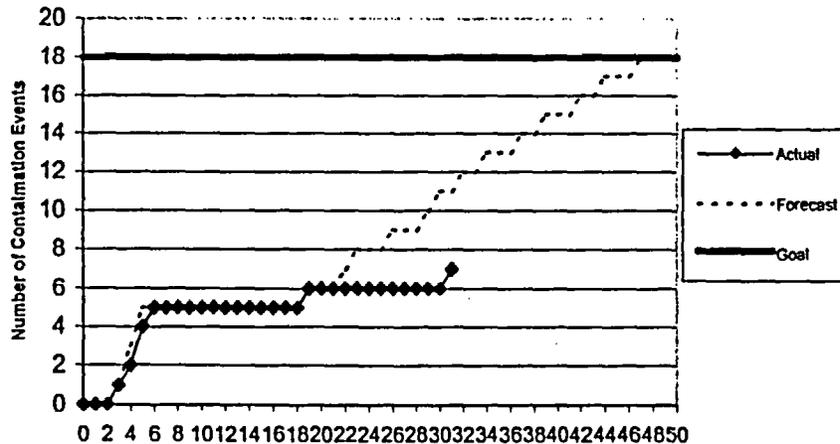
Meets:	≤ 75 Rem	Actual Cum.	
Exceeds:	≤ 71 Rem	Dose:	51.104 Rem
Meets:	≤ 18	Exceeds:	≤ 12
		Actual PCE's:	7 8

PCE #7 on 5/4, individual performing cut-out of valve 1RC-526B was found to have 10,000 ncpm contamination on modesty bottom (and 2,000 ncpm on leg).

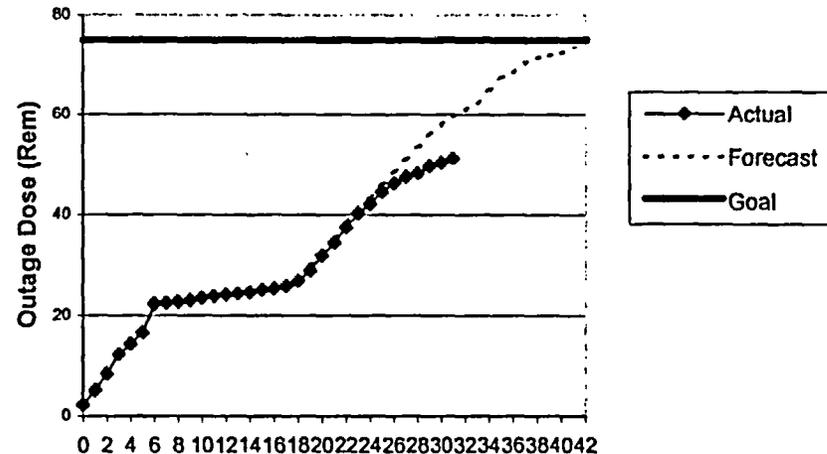
Responsible Manager/Owner

Stu Thomas

Personnel Contamination Events



Cummulative Dose Exposure



Outage Status Report

Plant: Point Beach Unit 1 Day: Thursday Today's Date / Time: 5/06/04 0400

Outage Duration: Day 33 Of Refueling Outage Number U1R28

Safety Status

Industrial - Within the last 12 hours
 OSHA Recordables 0 First Aid cases 0 Significant near misses 0
 Total for this outage 1

Summary:

Radiological
 Dose to date 51.104 Projected to date * 59.488 Outage Goal ≤75 R
 Difference -8.384 * Reforecast on 4/23 Number of PCEs 8

Summary: 5/5/04 - An individual performing disassembly of valve ISC-953 was contaminated.

Nuclear
 Significant human performance errors and events in last 24 hours 0

Summary:

Plant Status

Mode: Hot Standby (Mode 3) Hot Shutdown (Mode 4) Cold Shutdown (Mode 5) Refueling Shutdown (Mode 6)
 RCS: Temperature: 84 Pressure: Vented to Atmosphere RV Level: Refueling Height
 Time to Boil: 34 hours

Shutdown Safety Assessment Protected Equipment:

ex 4

Major Activities Completed in Last 24 Hours

- 1B-42 MCC Vertical Bracing
- MOB Package IWP-037-07
- 1Y04 Instrument Panel

Critical Path and Near Critical Path Activities (Next 24 Hours)

- 1B-42 MCC Bus and Bucket Work
- CVCS Restoration
- Restoration of 1B-42
- 1P-15B SI Pump Seal Repair
- Reactor Head Repair
- SI System LRPM Testing

Significant Outstanding Issues

Date	Issue	Due	Responsibility
4/28/04	1W-3B Shroud Fan Backdraft Damper FME	5/09/04	Terry Guay
5/03/04	Reactor Vessel Head Repair Penetration #26	5/16/04	Jim Schweitzer

Upcoming Major Milestones

	Scheduled		Actual			Scheduled		Actual	
	Date	Time	Date	Time		Date	Time	Date	Time
Cooldown <200°	4/03/04	2100	4/03/04	2230	RCS Fill & Vent	4/23/04	1500		
Head Lift	4/09/04	0900	4/21/04	1550	Heatup >200°	4/25/04	0900		
Refueled	4/14/04	0300	5/02/04	1848	Reactor Critical	4/28/04	0800		
RV Headset	4/18/04	1900			On-Line	4/30/04	0100		

Point Beach Nuclear Plant
PBNP SHUTDOWN SAFETY ASSESSMENT AND FIRE CONDITION CHECKLIST
OUTAGE SAFETY ASSESSMENT

UNIT: 1

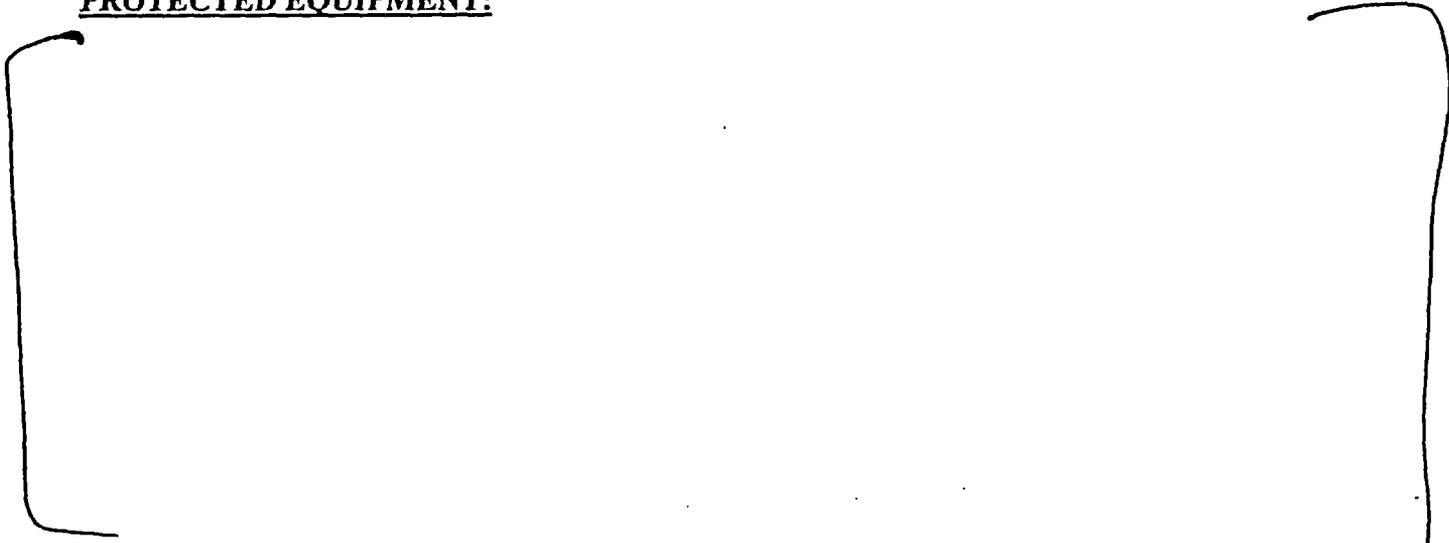
DATE: May 6, 2004

TIME: 0200

KEY SAFETY FUNCTIONS:

REACTIVITY:	GREEN
CORE COOLING:	GREEN
POWER AVAILABLE:	GREEN
INVENTORY:	GREEN
CONTAINMENT:	GREEN
SFP COOLING:	NA

PROTECTED EQUIPMENT:



COMMENTS:

RCS Time to Boil is 34 hours
Fire Protection Condition IV: Credit is taken for fire rounds as fire prevention contingency

ex 4